

Patient name: _____ Date of birth _____ / _____ / _____
 (day) (mo.) (yr.)

Sponsor SSN: _____

Medical Records Location (circle one) : USNH CAPO GAETA

Screening Questionnaire for Intranasal Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child intranasal influenza vaccine (FluMist®) today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	YES	NO	DON'T KNOW
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist®) in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the person to be vaccinated have a long-term health problem With heart disease, lung disease, asthma, kidney disease, metabolic Disease (e.g., diabetes), anemia, or other blood disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is the person to be vaccinated between the ages of 5 and 17 years and receiving aspirin therapy or aspirin-containing therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment (such as in a hospital room with reverse air flow)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Vaccine	Manufacturer	Lot Number	Exp Date	Dose	Site	Given by
FluMist®	_____	_____	_____	_____	_____	_____

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

